Private and Nongovernment Providers: Partners for Public Health in Africa

Conference Report
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Background

The Data for Decision Making Project (DDM) (Cooperative Agreement No. DPE-5991-A-00-1052-00), sponsored by the USAID Africa Bureau's Health and Human Resource Analysis (HHRAA) Project (Project No. 689-0483), convened an international conference on *"Private and Non-government Providers: Partners for Public Health in Africa,"* November 28-December 1, 1994, in Nairobi, Kenya. The purpose of the conference was to address the major policy question:

> *How can countries make better use of public and private health resources to further national health goals?*

Underlying this major question is the premise on which the conference was based and which was affirmed by the conference participants: that private providers can make and are already making significant contributions to enhancing the coverage and impact of important public health interventions.

The conference produced six implications or steps that have to be taken on a country-by-country basis to build a more conclusive, pragmatic, and empirical base of knowledge, shared understandings, and useful information exchanges for the purpose of health policy decision-making. In brief, those implications are as follows:

Summary of Implications

1. Be Country-Specific

Each country needs to determine which actions are necessary, possible, and desirable to build the public/private partnership in health care provision. The nature of the partnership will vary from country to country as political, economic, geographic, and cultural circumstances vary.

2. Build Trust

To overcome mutual suspicions, all of the many perspectives involved in public health care—including providers, government policy-makers, donors, researchers, suppliers, and, not least, consumers or health care clients—need to participate in the review and deliberations of relevant data for policy.

3. Agree on Definitions

Shared understandings and agreements on definitions are necessary to promote effective communication and information-sharing within and across countries. However, any typology (or other analytic device) must be tested for its appropriateness to each unique country setting before being applied to the region.

4. Develop a Flexible Approach

The conferees debated a suggested methodology for describing and assessing the private sector and for undertaking research studies to create a reliable information base. The methodological guidelines presented to the conference are a starting place for work within countries on identifying specific strategies to increase the

private contribution to national health goals.

5. Build a Database

Data on private providers should be developed specific to each country. The data should lead to a common understanding of what are public health priorities, the types of providers and their roles, their costs and opportunities, and the national policies and resources that affect those providers and the public health.

6. Develop Communication Strategies

Participants urged that several activities be undertaken in following up the conference. These include improving data capture within countries, promoting networking among countries with regional clearinghouses, and communicating information internationally through such means as newsletters, videotapes, and similar conferences.

Conference Setting

The conference drew representatives from 14 African countries in addition to selected representatives from the United States and Europe.

Participants

The participants included 77 private and non-government health care providers, government health policy-makers, health care researchers, and representatives of American and European donor agencies and other international agencies and NGOs. Among the participants were such private providers as physicians, pharmacists, and traditional healers.

Some 14 African countries were represented: Burkina Faso, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Niger, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe.

Objectives

Focusing on the policies and issues affecting private and non-government health care provision in Africa, the overall purpose of the conference was to review existing and new research data from the perspective of participants' own experiences, and draw from their discussions an action agenda for building an African partnership of private and non-government providers in public health. The specific conference objectives were:

1. To review and discuss the findings of new research, particularly recent case studies on private and non-government health care provision in Kenya, Senegal, Zambia, and Tanzania, which included assessments of:

- The size, scope, and distribution of private providers.
- The current and potential role of private providers in promoting the public health agenda.
- The conditions of consumers' demand for health services and the economic and regulatory factors that determine the supply of privately provided health care.
- Existing linkages and opportunities for private/public partnerships.

2. To discuss the implications of these case studies and other data for policies related to private and non-government health care provision.
3. To generate ideas and recommendations for an action agenda for private and non-government health care provision in Africa.
4. To prepare an action agenda for policy-makers, international donors, and researchers.
5. To plan the dissemination of background materials and concept development on policies and experiences of private and non-government providers in African health care.

Participants discussed the results of the case studies of public/private provision of health care in Kenya, Tanzania, Senegal, and Zambia conducted prior to the conference in 1994. These case studies were summarized and described in a conference paper, Summary: Private Providers' Contributions to Public Health in Four African Countries. The case studies were conducted largely on the basis of DDM's Assessing the Private Sector: Using Non-Government Resources to Strengthen Public Health Goals -- Methodological Guidelines. Both documents were distributed in the Conference Workbook. (NOTE: These and other conference documents are available through the DDM Project of the Harvard School of Public Health.)

The case studies were presented as examples of country analyses for discussion and for follow-up dissemination throughout the African region.

Format

The four-day conference was organized into 15 discussion and implications sessions.

Discussions

The Conference Workbook provided the focus for each discussion (Forum) session. These included the characteristics, services, determinants, linkages, and opportunities of private provision of health care. Usually, these Forum discussion sessions focused on specific themes with formal presentations from the case studies and related research.

Implications

The conference synthesis of proceedings reported here is mostly based on informal participant discussions during the implications sessions. For the purpose of this report, all background papers, notes from discussion and implication sessions, and many hours of videotape were reviewed for main themes. This kind of thematic content analysis is qualitative, and does not give firm statistical statements.

Other Activities

Among other activities, participants visited local private health care facilities and joined in a simulation exercise of building a partnership for public health.

Different participants served the agenda in different ways. For example, policy-makers and donors presented their perspectives on such issues as financing and policy reforms; while private providers presented their perspectives on such issues as government regulation, service quality, training, and credit requirements.

In addition to the formal case study presentations, researchers from other institutions contributed their findings from studies of private providers in Eritrea, South Africa, and Thailand.

Contributing Agencies

The U.S. Agency for International Development was represented by officers or other representatives of: the USAID Missions in Kenya and 13 other countries; A.I.D.'s Regional Economic Development Services Organization; as well as the Africa Regional Bureau and the A.I.D. Office of Health in Washington. The conference was also attended by three World Health Organization representatives.

Private groups included the Harvard School of Public Health, which was the lead agency in developing the conference; Abt Associates, which contributed two of the case studies; Management Sciences for Health representing the Kenya Health Care Financing Project, the London School of Hygiene and Tropical Medicine; the World Council of Churches; and Intercultural Communication, Inc. (ICI), a DDM/Harvard subcontractor, which organized the communication and logistical requirements of the conference.

Case Study Findings

The principal information made available to the participants as a basis for discussion was the paper, Summary: Private Providers' Contributions to Public Health in Four African Countries. Both the summary and the individual case study papers were included in the Conference Workbook. The major findings of these studies included the following points:

Characteristics: Who are the Private Providers?

Each country has a diverse mix of different types of private providers, ranging from traditional to modern practitioners and from individual and ambulatory practices to

"The pharmacies are like the modern clinics ... most are urban-based, while the greatest need for them is in the rural areas .... Today, they've changed, and their role is much different from the past. They give more services than just medicines ... more consultancy, more counseling, even basic diagnostics .... Their one-stop services are meeting greater patient demand."

large hospitals. For the study, providers were classified by their for-profit/non-profit commercial orientation and by their type of ownership—for example, individual/group-owned practices, mission/charitable clinics, employer-provided clinics, and others.

While countries vary, there is a general picture of weakened economic conditions, over-burdened and unevenly distributed public health systems, slowing or stagnating improvement in health status indicators, and increasing government interest in contributions the private sector might make to national health goals. Overall, the flagging economic conditions and the general slump in public health services make it all the more urgent that appropriate policies be developed for public/private collaboration in health services delivery.

It is widely perceived that the number of private providers and the variety of their services are growing. The growth of private providers may reflect the movement in each nation's economy, with the number and type of providers increasing as public health funds and services deteriorated. In the 1980s-90s, in particular, governments tended to relax licensing and regulation of private providers and to relax the prohibition of public-sector personnel working in private practice. Today, it is not unusual to find, say, a private dispensary owned by a MOH physician that is run by a nurse or medical assistant, with the doctor keeping part-time and evening hours.

Services: What Do Private Providers Do?

While the government is the largest health provider, the size and distribution of the private health sector make it an important part of national health care. The distribution of both public and private services tends mostly to favor urban areas with larger populations, higher employment, and better ability to pay. Both the supply of and the demand for services are more for curative than preventive health.

- **Missions:** Of all private providers, except traditional healers, only missions concentrate in rural areas to serve the poor and underserved. Their relationship with government is not uniform. Yet, whatever the relationship, church-based providers are important in all four countries for reaching rural areas with preventive as well as curative services. However, while mission services are typically not expanding, the for-profits are expanding rapidly.
- **Employer-Based Services:** Some countries require that large employers provide health services or reimburse health expenses for their employees. Such services, including government parastatals, are often among the best in the country but are usually available only to employees and their families. They provide all types of services, but mostly outpatient care through clinics, pharmacies, and specialty laboratories. Like the for-profit providers, companies and parastatals tend to concentrate their services in urban areas.
- **For-Profit Providers:** The "modern" for-profit providers are the fastest growing segment of the private health sector, although growth has been uneven and poorly documented. They are mostly in urban areas, where there is a concentrated market, higher ability to pay, and better access to supplies and transportation. They provide a range of hospital and ambulatory services, and

the latter are significant in all countries. They are less likely to provide preventive services than are the non-profit NGOs or church-affiliated facilities.

- Pharmacists/Drug Stores: In all four countries, pharmacies are the largest suppliers of over-the-counter, prescription, and non-prescription medicines. They tend to concentrate in urban areas and are more closely regulated by the government than are other providers. Their role is expanding beyond dispensing medicines. It is not unusual to find "one-stop" pharmacies that provide medical diagnosis, patient counseling, and treatment in addition to dispensing drugs.
- Traditional Practitioners: Healers, charismatics, and birth attendants are often the most accessible and most important source of rural health care. They, too, tend to be "one-stop" sources of care—diagnosis, medicines, and treatment. There is new interest in the potential contribution that traditional healers, with modern training, could make to the nations' health.
- Community-Based Services: In line with governments' efforts to increase rural health services, more community-based and community-owned clinics and pharmacies are emerging in rural places. They may be managed by a village committee and provide such services as medicines, medical supplies and health education; support immunization programs for children's communicable diseases; and treat malaria, diarrhoea, worms, and skin and eye infections. Some include a form of health insurance whereby community resources are pooled to help families through catastrophic illnesses.

In summary, there is little information on private services in any country. The growth of the private, especially for-profit, sector has been as uneven as it has been rapid. In the absence of good monitoring systems, it is difficult to track new facilities and the type and quality of their services. There is some evidence that malpractice is growing.

Determinants: What Things Affect Private Services?

The most important demand factors affecting people's use of private services are income and urban/rural place of residence. And the most constraining supply factors are lack of access to capital and high taxes on imported drugs, medical supplies, and equipment.

- Demand-side Determinants: The demand for private services is high—in some countries 40 percent or more of consumers use private and mission services and over-the-counter drug purchases. Household income is the greatest constraint on use of private services, with lower-income groups making more use of drug sellers, small providers, traditional healers, and mission and mosque services. Other important factors related to use of private services are education, residence, quality of services (government services are often rated lower as compared with private services), availability of health insurance, and government "user fees"—which may lead to greater demand for private modern services.
- Supply-side Determinants: MOH services have deteriorated with falling real government funding—drug shortages, lack of essential supplies, overcrowding, and long delays. Despite problems getting credit, the economic and

"Health policy is wrong (to) ignore the traditional healers and charismatics. For many rural, poor people, the traditionals are the only accessible source of medicines and treatments - no matter how good .... People believe in them and they are everywhere .... Public education is a problem. Why should people travel to the far-away city, when they believe in the healing powers of the traditionals?"

"...private providers can make important contributions to public health care .... we have seen good models of collaboration in numerous African countries (and) substantial scope for developing ... new public/private linkages to improve coverage, quality, and affordability of essential services .... including joint efforts in provision and financing as well as .... incentives and subsidies for private providers, better monitoring and regulation, and sharing of training and information."

political climate in the four countries favors the growth of private health services. Governments' legalization or reduced restrictions on private providers have contributed to their expansion. Now, the greatest constraints on providers are lack of access to capital and credit, high taxes on imported drugs and medical equipment and supplies, and lack of trained medical personnel.

Overall, government policies, regulations, and licensing procedures have not constrained private sector growth, but have encouraged urban concentration.

Linkages: What Links Exist Between the Public and Private Sectors?

Three main linkages between the public and private health sectors are (a) ***laws and regulations***, which tend to be weakly enforced and show large gaps in their application; (b) ***communication and coordination***, which often falls short of intentions and provide few fora for policy dialogues; and (c) ***service delivery and financing***, which tends in both sectors to be curative, thus resulting in service duplication. The public/private relationships are not always clear, but their collaboration is not new. In particular, the non-profit mission sector has existed for many years, with a generally sound relationship with government. Governments' relations with for-profit providers typically have been less than sound.

A major linkage in service delivery has been public financing of private providers. This can be direct payment, as in direct payments in cash or kind for service (Kenya NHIF pays private hospitals as well as public hospitals, most countries provide some supplies, like vaccines or ORS to private doctors and pharmacies free or low cost.) And it also can be partial, as in subsidizing inputs (low taxes on drugs, medical equipment) or giving incentive payments for certain actions. This has been an important area of public action affecting private providers.

For family planning services and contraceptive supply, private providers make a major contribution in some countries. For other public health problems, private providers make varying contributions by, for example, treating common childhood diseases such as diarrhoea and respiratory infections, giving immunizations, assisting deliveries, treating malaria, treating sexually-transmitted diseases and tuberculosis. Their clientele and their services vary by type of provider (say, missions vs. a nurse's outpatient practice vs. drug sellers) and their urban/rural locations.

Implications: What are Opportunities for Improving Public Health and Private Provision?

All the case studies recommended that governments and donors recognize the current and potential importance of private providers in health care delivery. While the lack of information limits the assessment of private providers and their potential for improving public health, it is known that they are not homogeneous in structure, fees, composition, output, location, or susceptibility to government leverage. Because of the wide variety of private providers, policies to enhance support for national health goals must be tailored to the needs of each type of provider.

The improvement of health service delivery, reach, and impact will require a more

inclusive and higher level of policy dialogue than exists at present, as well as programming collaboration with private providers directed at (a) increasing available health resources; (b) increasing efficiency of resource use; (c) increasing equity of access; and (d) increasing effectiveness of services.

To increase private providers' contributions to public health requires that governments reduce constraints on private services and improve monitoring and coordination of those services. Steps might include continued decentralization of health decision-making, improved information-sharing, improved modern medical training, relaxed restrictions on public health professionals working in the private sector, and such other reforms as setting achievable standards for quality and appropriate use of services and providing direct material or financial assistance through incentives and subsidies.

The central problem for governments is to recognize people's demand for health services and to attempt to meet that demand through any conventional or unconventional means—pharmacies, traditional healers, birth attendants, community-based services—that effectively reaches and appeals to people where they live and that provides higher-quality, affordable services than people have access to now.

In short, in the views of the participants, the improvement of national health status requires governments to use more effectively the health services that are already in place. To do so, national planners must develop specific models of public/private collaboration based on specific health problems, types of providers, geographic locations, target populations, fees paid, insurance coverage, and types of services—disease treatment, referral, preventive care, and health information. Such models should make explicit the costs and benefits of improved integration of private and public delivery of services aimed at improving the public's health.

Of course, there already are a number of models in various African nations of successful public/private collaboration, especially in immunization programs, family planning efforts, and treatment of children's illnesses. But the models thus far have not been developed comprehensively nor disseminated widely. Moreover, in the view of some participants, the efficacy and cost-effectiveness of the models have not yet been sufficiently evaluated.

Yet, the consensus view of the conference participants was that private providers can make substantial, positive contributions to public health care. And, as such, there is great scope for developing a wide variety of new public/private linkages to enhance coverage, quality, and affordability of essential services. These could include joint efforts in provision and financing as well as programs of public support (incentives, subsidies) for private providers, better monitoring and regulation, and sharing of training information.

In opening the conference, its convener, Dr. Peter Berman of the Harvard School of Public Health, identified two strands of policy action that have become clear in the last decade. The first policy reform activity has been the study and debate on how to expand the role of private agents in financing health care which may be additional to, or partially a substitute for, public sector spending. This has been the main focus of interest in the private sector in health in Africa.

The second, more qualitative strand of policy reform, has been efforts to enhance the role of private provision of health services. This second issue is more recent and very little is known

about the actual or potential public/private relationship; this was the focus of this conference.

However, for their deliberations, conferees were cautioned:

"....that the evidence is not yet available to support or discount many of the assertions that are frequently made about the quality and efficiency of the private sector. Instead, we have sought to identify the merits and weaknesses of different parts of the private sector." (Berman, 1994, p.7).

Discussion

Rather than to try to produce a technical agenda of specific policy and program actions to take in following up the Nairobi meeting, it was the consensus of participants that certain, preliminary steps have to be taken first to inform policy-makers.

While the conference aimed to prepare an action agenda for building the partnership for public health in Africa, the combination of perspectives and country experiences resulted in a universal sense among participants: (1) that such a partnership would need to be built country by country; and (2) that not enough is known with certainty about private providers to make informed policy decisions on their future role and potential in serving national health goals.

As such, rather than arriving at recommendations for technical approaches to the partnership, participants sought to discover consistencies in themes and issues across countries. Establishing commonalities was in the participants' view a first step that has to be taken as a basis for developing an action agenda.

"At a political level, Governments are beginning to adopt ... 'The New Order' towards the private sector. In (my country) this has meant the effort to harness new resources in support of national health goals: We have focused primarily on (the) mining and mission sectors, but now are also looking towards the private for-profit sector in our search for new partners. We are promoting a freer exchange of information, the opportunity for dialogue, the formation of shared values and ideals, and looking for win-win solutions to shared problems .... We want to be a 'listening government.' "

"The aim of the conference was to foster exchange among policy makers in governments and international organizations, researchers, and private and non-government providers on the partnerships for improving the public's health in Africa .... Three important points that emerged (are) suspicion between the actors ... (which can, through conferences like this, be) largely overcome; challenges to medical orthodoxy ... (such as) pharmacists expanding their role in health service delivery (and) how this challenge plays out will depend on the relative strength of the different professional bodies; and the need to start early in developing an appropriate legal and regulatory framework for private providers."

Accordingly, this report presents the principal themes and issues identified at the conference. Certain implications are drawn from these themes. The first result is a list of barriers that were identified as obstructing efforts to develop specific strategies to increase the private contribution to national health goals. In brief, those barriers include the following:

Barriers to Public/Private Collaboration

African Nations are Highly Heterogeneous

There is significant variability within and across countries—in languages, geography, customs, behavioral patterns. Each country has its unique colonial history, which has affected its social, economic, and political institutional development, its provision of health services, and the relationships of public and private health providers. And, indeed, the four case studies found important differences in the type of private providers in each country and in the roles they play in health service delivery.

Accordingly, the participants' view is that each country situation is unique, to the extent that actions must be developed country-by-country instead of through a regional approach. And, from country to country, the problems and the solutions related to private- and public-health provision are different. Until more is known about the similarities and differences of health systems among countries, participants felt that discussions of developing a common core of data and a common study approach will be inconclusive. Their caution to donor agencies is that there may not be a pan-African policy agenda or approach.

Typically, countries also lack a uniform policy framework for prescribing specific steps to improve the public/private partnership. Each country's legal and regulatory framework should be in place as a basis for defining and resolving problems of private and public health provision. This is not always the case. And some of the policies that are in place, such as prohibitions on public health professionals working in private practices and high taxes on imported drugs and medical equipment, act as constraints on private sector development.

Limited Resources Affect Research Priorities

While each country situation is unique, generally African nations are facing difficult economic times. Governments are strapped for health funding to address problems of lack of trained personnel, lack of health facilities, lack of medical schools and professional training, lack of equipment and supplies, and others. One problem common to all countries is that resource limitations seriously inhibit national efforts to monitor and regulate private providers effectively.

Against the backdrop of other critical needs for funding, research on the nature and potential of private- and public-sector collaboration is currently a rather low priority. While participants generally felt that more conferences such as this one would be useful, they see the greatest need for improving the data base and improving the dissemination of data as preconditions to elevating the priority for research.

However, participants recognize that the presence of data alone is not enough to improve communication and use of research findings. There is not enough existing, trustworthy information on public/private health services across African countries to give reliable guidance for action steps. It is

debatable how much of a common core of data could be obtained in different countries. There are a few country-specific studies, but none has been undertaken for regional guidance.

Similarly, there is no uniform methodological approach to the study of public/private relationships across countries. The guidelines for assessing the private sector that were offered by Harvard for conference consideration were thought to be a good "starting place." However, the consensus was that each country should study its own situation in its own way. But, in this light, one concern voiced is that country-specific studies will not add up to a region-wide data base if they are greatly different. Further, technical agreements on methodology would be needed to implement a regional approach—e.g., common methodology, sampling frames, analysis plan, reporting criteria. Such agreements may be difficult to obtain.

Distrust Affects the Public and Private Relationship

There is much suspicion between members of the private and public health sectors. Much of the problem of low trust is due to little awareness of the private sector's composition and health contribution as well as due to the lack of involvement of all concerned parties in policy debates. Providers on each side suspect the motives of the other side. Ignorance and misperception thrive in the absence of data.

One problem that creates distrust is the lack of representation of relevant parties. That is, not everyone who would be party to building a public/private partnership for health delivery is invited to the table to discuss the issues and problems. Notably missing from such discussions are traditional healers, manufacturers and suppliers, insurance companies, and consumers/recipients of health services.

On the other hand, not all relevant parties may be willing to join the policy discussion. Traditionally, relationships between government providers and mission (charitable) providers tend to be quite good, as the missions are recognized for serving areas and people underserved by public services. Generally, however, competitiveness rather than cooperation marks the public/private relationship. The sense of competition will not abate until more is known about the actual and potential roles that different types of providers may serve in furthering national health objectives.

Communication Among Parties is Poor

There is generally such little interaction between public and private health providers that participants on both sides are not sure of the ground on which they stand with respect to possible collaboration.

Public and private providers are rarely involved together in mutually supporting front-line service delivery. While there is some collaboration at the level of the district, it is usually not within the scope of mutually agreed programs and objectives. Rather, each group goes its own way. The principal mode of sharing experiences is the presence of public practitioners working in private clinics. Yet, in some countries, such moonlighting is illegal.

In situations in which there is low awareness, limited interaction, and little shared experience, it is almost axiomatic that there is poor communication between members of the public sector and the private sector. Until communication improves, stereotyping and suspicion will persist.

Parties Lack Agreement on Roles and Objectives

There is little agreement about the nature and potential of the public/private health relationship. Little attention has been paid to the nature of the private sector. Little is known about its composition, services, or actual or potential roles in advancing the national public health agenda in any country in the region.

Given the lack of data, there is little agreement on who are private providers and where to start in trying to better understand their health roles. And there is little agreement about the role they play in ambulatory and inpatient curative care or in other public health services such as prevention and health education. There is, however, strong agreement that traditional practitioners (healers, spiritualists, birth attendants, bone-setters, herbalists, roadside providers/"kiosk" clinics, shops, pharmacies, and others) are important private providers.

Thus, given the lack of data, lack of definitions, and lack of assessment methodology, it is not surprising that there is little firm agreement on the nature of the problem or, indeed, whether there is a problem or what to do about it. Many public providers do not see the contributions of private providers as necessary for achieving public health goals.

Information Exchange and Dissemination are Weak

There is no strategy in place in the region's countries for systematic dissemination of information on the private sector and on its relationships with the public health sector. Among specific avenues for communication, there is no evidence that education about the private sector has yet achieved any place in the curriculum in public medical schools and training centers.

Similarly, there are few learning opportunities or public fora for sharing views or for exchanging hard data between public and private providers. It is not a subject that is widely taken up at donor- or government-sponsored medical conferences or workshops.

Summary

The above are the major conclusions of conference discussions of barriers to public and private health service coordination. In addition to the problem of little information and low awareness, it is notable that two themes that run through these barriers are closely related problems of human relations. The first is low trust between members of the public sector and the private sector, and the second is poor communication between them.

When related issues are combined, the list of barriers gives six actions (next page) that conference participants believe have to be taken to strengthen the elements of policy reform aimed at improving the public/private relationship in health provision.

Presuming resources would be available, the six-step prescription principally calls for more and better information and more and better information exchange as a basis for creating a policy-and-action dialogue. In this respect, the conference produced an action agenda for improving intelligence rather than an action agenda of specific policy alternatives (see figure 1 below).

Policy Issues

Of course, numerous policy and programming issues were discussed among the participants. But no firm consensus emerged from these discussions as to specific actions to be taken. Some of the major policy questions discussed were:

- Incentives: The need for more creative use of public incentives and fiscal tools (e.g., taxes, subsidies, in-kind contributions) to increase private provision of services of national priority (e.g., treatment of major childhood diseases, reproductive health) and to reach underserved populations in both urban and rural areas. Special consideration is needed to encourage private providers to serve urban poor and rural areas through, perhaps, sharing investment costs for equipment, facilities, import duties, and others.
- Monitoring: Without making licensing or regulation more restrictive, the need for strengthening government monitoring and regulatory capacities to provide possible improvements in the quality and accountability of private healthcare provision.
- Program Models: The need for developing "new models" of collaboration between the public and private sectors to increase private providers' contributions to the national health agenda. This includes more involvement of private practitioners in public health debates and legislative acts—including their participation in discussions of rate-setting, credentials, service types and locations, incentives, and other issues.
- Service Coverage: The need for extending coverage to the poorest populations through, for example, national insurance schemes, employer-based services, social security mechanisms, specialized credit institutions, and the like.
- Awareness: The need for improving consumer knowledge and behavior through public education and motivation; in particular, to educate consumers in preventive health measures and reduce the demand burden on curative services.
- Education/Training: The need for producing more well-trained medical professionals and strengthening national capacities (e.g., facilities, applicant selection, curricula) for higher quality medical education and training; and the need for incorporating private health provision into the public health curriculum—thus, to recognize the potential roles and contributions of the private sector to national health. This includes new attention in the formal medical curriculum to traditional health-care systems and practices.
- Credentials: The need for the development and application of country-specific standards for evaluating, certifying, licensing, and regulating private health providers (e.g., physicians, clinicians, technicians, pharmacists).
- Traditional Practitioners: The need for re-evaluating the certification of, and the contributing roles played by, traditional healers and practitioners for the purpose of bringing them into the public health debate and for employing their services - such as carriers of modern health messages—where such

"Privatization of public health services and increasing ... private health care provision are strategies (receiving) growing amounts of attention over the past decade. They have arisen out of a number of concerns and developments (including) the shortcomings of the public sector action (and) shortfalls in performance and outcomes from highly centralized, top-down service strategies .... Another factor (is) the fiscal crisis faced by many states (with) dramatically reduced economic growth, or even reductions in national income .... A third factor of importance has been the growing recognition that, whatever the strengths and weaknesses of public action, the private health sector exists and is sizable in many countries."

"In the immediate term, policy changes in public/ private financing or provision arrangements (could be) introduction of paybeds in selected hospitals (which) may stimulate interest in voluntary health insurance .... introduction of partial payments for drugs at health clinics and centers .... Contracting of some non-clinical services in hospitals .... Encouraging new NGO groups to act as service implementers (and putting) private practices under closely monitored public regulations."

Six Steps Toward Policy Decisions

1. **Conduct data collection and research on a country-specific basis.**
2. **Attack the problem of trust—bring everyone concerned to the policy table.**
3. **Agree on definitions of private providers and their services.**
4. **Agree on the methodology for creating an appropriate data base.**
5. **Build the data base.**
6. **Take actions to communicate data implications to all concerned parties.**

figure 1: The six step prescription

services complement and extend coverage of the modern health system. This includes efforts to capture the treatment knowledge of healers and charismatics, which may be lost to modernization.

While these and other policy issues were raised, specific action recommendations were not made. That is, while many agreed that better monitoring and accountability are necessary, there was no real agreement on how to achieve a better system. Rather, the conference emphasized that the first, follow-up step is to improve intelligence as a prerequisite for sound policy-making.

The following are the prevailing views of the conference regarding six steps to be taken in developing an information base for policy-makers.

Country-Specific Approaches

African countries are highly heterogeneous. Each country presents a unique context for developing a partnership. The size, composition, and role of private providers, as well as the extent of the linkages with the government and among providers, vary greatly among countries and within countries. The circumstances of each country's development shapes the partnership for public health in that country. Moreover, the management capacity of the government and of private providers to strengthen the base for developing partnerships is different from one country to the next.

The conference demonstrated that, in trying to find regional solutions, the uniqueness of each country's own circumstances should not be underestimated. There can be no regional or sub-regional approach to analyzing public and private health provision until it is known with certainty whether and how the conditions in each country are similar to or different from neighboring countries. The participants felt that uniform approaches, standardized typologies, or other analytic devices should first be tested for appropriate "fit" within countries as a basis for determining the fit across countries.

For example, to use standardized categories of a typology of private providers that would promote a uniform approach to the private sector in all countries, some of the elements that participants felt have to be considered for each country include: the terminology used and its different meanings; the cultural context in

which health services are delivered; the varying social and economic systems and issues in each country; the government's historical relationship to the private sector and the level of involvement of both public and private providers; and others.

Also at issue are such questions as, who would define the typology—the public sector or the private providers themselves? Would it clarify ownership and control of services? Would it be sufficiently flexible to accommodate unanticipated cases or future conditions? And would its purpose be well understood by all parties

"Collaboration in some of the countries is at an embryonic stage. In the past, some distrust and lack of understanding prevented further collaboration (and created) some confusion on the (role) of the private sector. In most instances, collaboration with the MOH (was) only in terms of licensing. An exception was Burkina. A new program is in place to provide training support for the private sector, provision of commodities (contraceptives) at subsidized prices .... access to medical equipment. The private sector, in turn, is allowing inspections and providing statistical information."

Implications

affected?

It was the consensus of the conference that a typology of providers is necessary, but the typology should be adapted to each country's specific circumstances: "Typologies are useful … but we need to have typologies within contexts."

Developing partnerships is an evolving process. Once started, each country must continue to develop partnerships, strengthen linkages, and foster collaboration within its specific circumstances. Most countries represented have very limited development of public/private linkages, particularly in areas such as legal and regulatory policy, financing, and information. There are a few experiences of collaboration—both within the represented countries as well as in other countries—that can be used as background for strengthening collaboration within countries.

Although there is a need for more information on the private sector, there are a number of areas where countries are already taking action to strengthen public-private partnerships. These include financing private providers to deliver services of public interest, improving laws, registration and quality monitoring, and introducing collaborative local planning in cities, towns, and rural districts with not-for-profit and for-profit providers. Since experience needs to be gained, action can begin whenever public and

private sector collaborators are ready.

In sum, the first action in any country is to build common understandings among all relevant constituencies of, for example, what is public health and what is private provision. The second action is to acquire data on the actors and agencies of public and private health provision and on their existing links and potential role in contributing to national public health goals.

Build Trust

Any actions to build public/private partnerships in health care provision will require that trustworthy data are available and that all actors and agencies involved in health services be brought together at the decision-making table.

To-date, private providers have tended to be ignored during the process of governments' policy deliberations. In particular, the groups most poorly represented are traditional healers, health manufacturers/suppliers, and the citizen consumers. Also, it is felt that insurance companies should be represented as well. To reduce suspicion, all groups must be involved in deliberations; they have to share the same perspectives; and they have to contribute financial, human, and material resources to the problem.

In the views of the conferees, suspicion between private providers and governments has resulted from lack of consistent information on the characteristics, services, and determinants of private providers, as well as confusion about what is public health and the role of government, private providers, and consumers in obtaining better health. Most countries represented reported having inadequate knowledge about the size and composition of the private sector, what private providers can and do contribute to national health priorities, and the dynamics of public/private linkages.

According to one senior participant, Vincent Musowe of the Zambia Ministry of Health, part of the suspicion and antipathy of public health officials toward private providers derives from views that the private sector unduly absorbs health care personnel; that providers are too concentrated in urban areas; that they serve mainly upper-income consumers; that they get unfair tax concessions; that they use inappropriate and expensive technology; that they focus on clinical services to the detriment of preventive health; and that their motives are commercial and exploitative. To what extent these negative perceptions are based in fact is unclear, as the data do not exist to support this.

It was the prevailing view of the conferees that discussions based on reliable data and exchange of perspectives can bridge the suspicions that separate providers and government. In fact, one view expressed several times at the conference was that participants were surprised that their viewpoints had so much in common both across countries and across sectors:

> *"(A major problem is) suspicion between actors—government and private providers. Participants were able to talk freely, share perspectives, and to discover that they are not so far apart. In some measure, the stereotypes we in the public sector carry of private providers have been largely overcome" (Musowe, 1994, p.2).*

This type of reaction among participants speaks well to the value of conferences and other fora for the exchange of views. However, more diverse views are needed. That is, to seize opportunities for improving the partnership for public health, trust must be built among the broad base of partners involved—namely

government policy-makers (not only the ministries of health), private providers from the whole range of orthodox and nonorthodox providers, donors, and researchers, and not the least, the consumer or client of health care.

Create Shared Understandings

Effective public/private partnerships require common agreements and understanding of the many issues affecting private provision and public health specific to each country, including what is public health, the types of private providers and their roles, and national policies and resources affecting those providers and the public health. Information-sharing will not help the partnerships much if different participants have different meanings for what is shared. And, indeed, the four case studies found different private-sector components playing different roles in the various countries.

For the problem of varying definitions, and as one part of its methodological guidelines, Harvard presented to the conference a possible "typology" for classifying private and public providers in different countries.

As it was applied in the case study of Zambia, the typology addresses the question of "Who are the private providers?" It classifies providers along three dimensions: (a) commercial orientation—whether private services operate mostly for-profit or non-profit; (b) complexity of organization—relating to the level of services provided, size of organization, and other factors; and (c) the type of healing system involved—whether "modern" or "traditional" or some combination. See the typology in figure 2.

One of the reasons for developing the typology of providers was to help distinguish and clarify the relationships of the informal/traditional providers and other "modern" providers. This the participants felt is an important distinction to make and it will help ensure that further data collection and analyses of health systems do not ignore the traditional/informal sector.

The typology sparked considerable debate about its meanings and applications to individual countries. It was agreed that each country would have to determine for itself the appropriateness of the "fit" of the typology within its own borders.

Develop a Flexible Methodology

For discussion at the conference, the Harvard publication, Assessing the Private Sector: Using Non-Government Resources to Strengthen Public Health Goals -- Methodological Guidelines was introduced as a "starting place" for participants to judge whether and how a uniform analytic approach could be developed for country-to-country assessment of the contribution of private health care providers to national health goals. The purpose was to generate discussion with a view to improving the guidelines so that they could be used from one country to the next for the analysis of existing data and, as necessary, for the collection of new data for efforts to identify specific strategies to increase the private contribution to national health goals:

> *"On the one hand, to try to get private providers to do more in support of programs of public health interest or increase access to good quality services for populations in need; and, on the other, to reassess the public subsidies—both explicit and implicit—to the private sector and, where*

appropriate, to ensure that public funds are not being used to subsidize services that are not contributing to national objectives" (Berman, 1994, pp.6-7).

Again, the consensus was that each country would have to determine for itself the appropriateness of such an approach. However, like standard definitions, it was agreed generally that a common methodology is necessary both to describe and to assess the private sector within and across nations. As such, the guidelines, developed by the DDM project, were felt to be useful as a tool for structuring data collection and analysis. The guidelines address three basic questions:

1. Who are private providers?

As discussed above, a typology of providers would be useful in order to organize and analyze strategies. The suggested typology has three dimensions: commercial orientation, complexity of organization, and type of modern/traditional healing system.

2. What are the linkages between the public and private sectors?

To encourage effective public/private partnerships, we have to know the linkage between sectors, for example, sources of financing, type of public or private provision, regulations and licensing, taxes and subsidies and incentives, supply and demand conditions influencing provision, and monitoring and reporting activities.

3. What do private providers do?

In order to increase and improve private-sector contributions to public health goals, we need to identify, quantify, and assess the role of private providers in ambulatory and inpatient curative care and in other public health services, such as prevention programs.

Addressing these kinds of questions will aid government policy-makers in deciding on whether to increase or reduce public subsidies to private providers; whether to increase or decrease services for different populations that are subsidized with public funds; or whether to substitute private for public provision by knowing the circumstances under which it may or may not be feasible and may or may not produce more equitable and efficient services.

Of course, all other relevant parties—private providers, insurance providers, donors, health associations, researchers, and others—would benefit from new knowledge of who the private providers are in any country; the roles they play in curative and preventive health services; and where and how their services are available and where they overlap, compete with, complement, or supplement public services.

As the participants discussed, the private health sector is highly diverse. It is not a single, monolithic entity. Rather, different parts of the private sector tend to be important for different population groups and for different types of curative and preventive services.

Because of the unknown type and amount of diversity within each country, we need data-based conclusions. As a starting place for collecting and analyzing data, it was suggested that public and private services be assessed along at least the two dimensions of: (a) Type: The type of public or private service provision; and (b) Resources: The public or private sources of finances and other human and material resources committed to the different types of service provision.

Both the methodological guidelines and its typology of providers sparked considerable debate, with the eventual conclusion of

"We agree that governments have to take action, with new policies and new programs, to bring the public sector and the private providers together and in harmony ... and to get the best and the most benefit from each. But, first, our policy makers (need) more information to make informed decisions on which policies and which programs to implement."

Non-Profit Providers		For-Profit Providers
Employer Provided • Parastatals • Mines • Large Employers (Over 350 Employees) • Other Employers	Non-Government Organizations • Missions/ Christian Churches • Islamic Organizations • Other Non-profit services (e.g., Flying Doctors) • Local Non-government Organizations • Foreign Non-government Organizations	Modern Formal Sector • Private Clinics • Private Hospitals Pharmaceutical Retailers • Pharmacies • Drug Stores • Market Vendors Traditional Practitioners • Birth Attendants • Other Traditionals (e.g., Diviners, Bone-setters, Herbalists, Spiritualists, Healers)

participants that both would have to be adapted to each country's own situation.

Build a Database

The conference emphasized the need to identify, recover, and analyze all existing relevant data in each country before undertaking to collect new data through field studies. While it was felt that many useful data may be found in countries, there was no clear identification of data holdings in any of the countries represented at the conference.

The conference itself is testimony to the value of new or unknown information for stimulating the exchange of views and experiences even among those whose views are radically different and opposed. Many participants found greater congeniality of views than they anticipated. This kind of dynamic, which was simulated by the conference, is likely to function as well in the workaday world, as policy-makers are given an increasingly useful information base for their decisions.

Field studies undertaken in advance of common agreements are likely to be wasteful. The partnership should be built on a firm base of trustworthy data that are representative of public- and private-sector conditions in urban and rural areas as well as for different types of communities and income and ethnic groups. As a result of the data and the common understandings obtained from the review by all parties' perspectives, each country must determine its own action agenda and the means

to implement the agenda, and begin the process of implementing changes, as required.

By building on the common understanding obtained from the data and the resulting discussion, each country must define for itself what are its priorities for public health, the types and roles of providers included in the partnership, and the national policies and resources affecting the partnership for public health.

Develop Communication Strategies

The conference on private and non-government health providers drew participants from 14 African countries. It was very favorably evaluated by the participants, who typically said that the conference was a "very useful opportunity" for providers, policy-makers, donors, and researchers to affirm the importance of building partnerships for public health in many African countries.

The wide consensus was that the communication of the research findings and methodology discussed at the conference needs to be followed-up by regional and country-level dissemination activities. At present, plans for such dissemination do not exist, but the DDM project will explore how the use of its resources may promote systematic dissemination as a follow-on activity.

The participants urged that disseminated data should be broad-based, including all orthodox and non-orthodox health care providers ranging from the highest level of specialist care to the front-line care giver in the remotest of situations, from private entrepreneurs to complex, institutional providers. The data should include policy issues, such as, financing, training, legal and regulatory aspects, service quality and equity, monitoring and reporting, and information needs.

For specific dissemination activities, the participants offered three recommendations based on the spirit of the conference.

Country Research

With the leadership of each government, participating donors, researchers, and providers should collaborate to fund initial research and data collection on private providers specific to each country. The data from this research are essential for successful development of a partnership for public health.

Regional Centers

In both the francophone and anglophone regions, regional clearinghouses should be established with donor assistance, government participation, and provider support. Each clearinghouse would serve as a focal point for bridging international research activities with on-going country-specific activities, networking among countries, intra-regional study tours and workshops, and supporting country-specific activities.

International Dissemination

The international network, fostered by the conference, should be reinforced by continuous communication and intellectual support. A newsletter should be established to continue communication among the participants and to foster their activities in each country. The newsletter would further disseminate the methodologies reviewed in the conference as well as provide a continuing resource for inter-country exchange of data, tools, experi-

ence, and progress. A brief video presentation should be prepared from the extensive video footage from the conference to be used by participants in support of their country-specific dissemination activities.

Conclusion

Participants agreed widely that the Nairobi conference was a valuable impetus to furthering the public/private dialogue. For some of the participants, the conference was the first opportunity for public- and private-health providers to discuss the issues involved in a health delivery partnership. The frank and constructive exchanges of the Senegal representatives were a particularly good example to others. It was evident that many participants left the conference eager to continue the dialogue back home. And, indeed, the conference did motivate some immediate follow-up actions. In Zambia, for example, a national conference has since been designed based on the Nairobi conference to continue and to make more specific the dialogue on the nature and requirements of a public/private partnership.

Although there was a strong consensus on the need for better information and dialogue, conference participants noted that much was already going on and that much more could be done immediately.

- Many countries already have in place a variety of "models of collaboration" involving central, provincial and local governments, social insurance organizations, and a wide variety of for-profit and not-for-profit providers. These models range from health financing methods to specific disease control and family planning collaborations. Successful models can be replicated and expanded.
- Countries in different parts of Africa may have similar legal systems and experience with regulation of private providers. Countries could begin to collaborate on issues such as registration, the structure of public-private commissions, drafting of legislation and regulations, and processes for quality monitoring and improvement.
- User fees and insurance schemes are expanding in many African countries. What effect will public sector fees have on private provision and on patient welfare? Will private services be covered by insurance? How should providers be paid? What effect will insurance expansion have on public and private provision? Such important policy questions need to be answered, mainly by experimentation.
- The significance of traditional practitioners and the informal health sector was strongly emphasized. The consensus was that the potential contributions of the informal sector to public health goals must be examined with an open mind.

In summary, as this report has shown, the major implications that participants saw as actions for following up the conference are to enhance each country's data base, improve communication and interaction among relevant parties, ensure representation of all parties at the policy table, and build trust among parties through improved information exchange and more public/private fora.

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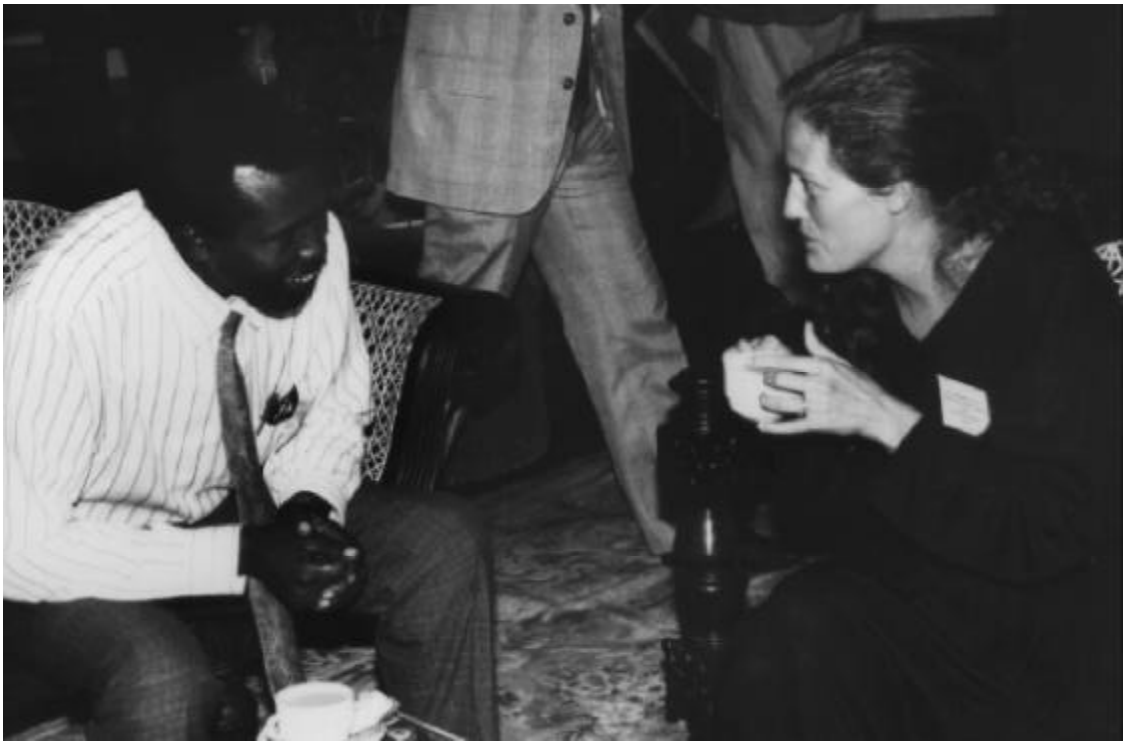

"Our primary policy question has been 'How can countries make better use of both public and private health resources to further national health goals. (Our) perspective ... to guide our discussions ... implies: That we see both public and private health care as instrumental to achieving some goals .... that we be pragmatic in our approach ... in further efforts towards these goals (and) that we be empirical — seeking 'data-based' conclusions on which to develop policy and program strategies."

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